
MCP: Special Projects

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The Department of Health Care Services (DHCS) may develop new managed care county programs or pilot projects in California to extend coordinated, competent care to identified populations. These special projects are designed to improve recipients' health status and to avoid unnecessary costs. This section describes managed care plans (MCPs) not mentioned in other MCP sections.

Note: MCP is used interchangeably with HCP (Health Care Plan). For example, recipient eligibility messages use HCP, while manual pages use MCP. Special project plan names, addresses, telephone numbers and HCP code numbers are included in the MCP: Code Directory section in this manual.

AIDS Health Care Foundation dba Positive Health Care

For information about AIDS Health Care Foundation, dba Positive Health Care, refer to the *MCP: Primary Care Case Management (PCCM)* section in this manual.

PACE

Program of All-Inclusive Care for the Elderly (PACE) plans receive a monthly capitated payment from Medicare and Medi-Cal to offer and manage the health, medical and social services needed to restore or preserve the independence of frail elderly individuals. PACE plans include the following:

- AgeWell PACE – Marin and Sonoma Counties
- «AltaMed PACE – Riverside and San Bernardino Counties»
- AltaMed Senior BuenaCare (dba AltaMed PACE) – Orange and Los Angeles Counties
- Asian Heritage PACE – Los Angeles County
- Brandman Centers for Senior Care – Los Angeles County
- Center for Elders Independence (CEI) – Alameda and Contra Costa Counties
- Central Valley PACE – Merced County
- Central Valley PACE – San Joaquin and Stanislaus Counties
- Chinatown Service Center – Los Angeles County
- Collabria Care (dba Providence PACE)– Napa, Solano, Sonoma Counties
- Concerto Health PACE of Los Angeles – Los Angeles County
- Community Eldercare of San Diego (dba St. Paul's PACE) – San Diego County

- Family Health Care Network – Kings and Tulare Counties
- Family Health Centers of San Diego – San Diego County
- Gary Mary West PACE – San Diego County
- Habitat Health Sacramento – Placer, Sacramento and Sutter Counties
- «Habitat Health South Los Angeles – Los Angeles County»
- High Desert PACE – Los Angeles and San Bernardino Counties
- Humboldt Senior Resource Center (dba Redwood Coast PACE) – Humboldt County
- «Innecare – Imperial County»
- Innovative Integrated Health - Bakersfield PACE – Kern and Tulare Counties
- Innovative Integrated Health - Fresno PACE – Fresno County
- Innovative Integrated Health – OC PACE – Orange County
- InnovAge Greater California PACE – El Dorado, Placer, Sacramento, San Joaquin, Sutter and Yuba Counties
- InnovAge PACE – San Bernardino and Riverside Counties
- K-Day PACE – Los Angeles County
- Loma Linda University Health PACE – Riverside and San Bernardino Counties
- MyPlace Health – Los Angeles County
- MyPlace PACE – Los Angeles County
- Neighborhood Healthcare PACE – Riverside and San Bernardino Counties
- North East Medical Services – San Francisco County
- North East Medical Services (NEMS) PACE – Santa Clara County
- OnLok PACE – Alameda, San Francisco, and Santa Clara Counties
- Orange County Health Authority (dba Cal-Optima PACE) – Orange County
- San Ysidro Health Center (dba San Diego PACE) – San Diego County
- Seen Health– Los Angeles County
- Sutter Senior Care PACE – Sacramento County
- Valley PACE – Fresno and Madera Counties
- WelbeHealth Bay Area PACE – Alameda and Santa Clara Counties
- WelbeHealth Inland Empire – Riverside and San Bernardino Counties

- WelbeHealth – L.A. Coast PACE – Los Angeles County
- WelbeHealth – Pacific PACE – Los Angeles County
- «WelbeHealth San Bernardino PACE – Riverside and San Bernardino Counties»
- WelbeHealth – Sequoia PACE – Fresno, Kings, Tulare and Madera Counties
- «WelbeHealth – Stockton PACE – Sacramento, San Joaquin and Stanislas Counties»

Eligible Recipients

Enrollment is voluntary and individuals qualify for plan services if they meet the following criteria:

- Are 55 years of age or older
- Live in a zip code served by a PACE Organization.
- Are certified by DHCS to need skilled nursing-home level of care.
- Able to live safely in the community without jeopardizing their health or safety

Non-capitated Services

The services listed below are non-capitated and are not reimbursed by PACE plans.

Contact an MCP for questions regarding capitated services. See the MCP: Code Directory section in this manual for plan addresses and telephone numbers.

For these listed non-capitated services, providers should follow fee-for-service billing instructions as specified in policy sections of the provider manuals.

- Alpha-Fetoprotein testing program laboratory services administered by the DHCS Genetic Disease Branch
- California Children's Services (CCS)
- California Community Transition (CCT) services
- County hospitals for the treatment of tuberculosis, or chronic medically uncomplicated narcotism or alcoholism services
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - Marriage, family and child counseling
- EPSDT onsite investigation to detect the source of lead contamination
- Federal or State governmental hospital (for example, Veteran Hospital or Prison Hospital) services

- Local Educational Agency (LEA) assessment services rendered to a member who qualifies for LEA services
- LEA services pursuant to an Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP)
- Newborn Hearing Screening Program services
- Newborn screening, mental retardation

Authorization

Authorization for services are approved by each plan's interdisciplinary disciplinary team, which consists of primary care physicians, nurses, physical and occupational therapists, social workers, recreation therapists, home health aides, dieticians and drivers. Each PACE plan must be reachable after hours to provide authorization for after hours services, except in the case of an emergency.

Border and Out-of-State Providers

Providers in designated border communities and out-of-state providers must obtain plan authorization when rendering services to plan members, except in case of an emergency.

Where to Submit Claims

All claims for capitated services must be submitted to PACE. Claims for noncapitated services must be sent to the California MMIS Fiscal Intermediary.

See the *MCP: Code Directory* section in this manual for plan address and telephone number information.

SCAN Health Plan

The Senior Care Action Network (SCAN) Health Plan is a Medicare Advantage Special Needs Plan with a comprehensive risk managed care contract to serve the Medicare/Medi-Cal dual eligible population. SCAN covers Medi-Cal state plan services plus offers home and community-based services to members who are determined to require nursing facility level of care. SCAN's goal is to provide comprehensive managed care to the senior population. SCAN also provides services to members who need long-term care in a nursing facility. Each of the following county's house two SCAN plans:

County	Health Plan
Los Angeles	SCAN – HCP 200 SCAN (Nursing Home Certified) – HCP 201
Riverside	SCAN – HCP 204 SCAN (Nursing Home Certified) – HCP 205
San Bernardino	SCAN – HCP 206 SCAN (Nursing Home Certified) – HCP 207
San Diego	SCAN – HCP 202 SCAN (Nursing Home Certified) – HCP 203

Eligible Recipients

Individuals qualify for SCAN services if they meet the following criteria:

- Are 65 years of age or older.
- Live in Los Angeles, Riverside, San Bernardino or San Diego.
- Have both Medicare Part A and B benefits.
- Do not have End Stage Renal Disease (ESRD) prior to enrollment.

Noncapitated Services

The services listed below are noncapitated and are not reimbursed by SCAN Health Plans. Providers should follow billing instructions for noncapitated services fee-for-service as specified in policy sections of the appropriate Part 2 manual.

- CCT services
- County hospitals for the treatment of tuberculosis, or chronic medically uncomplicated narcotism or alcoholism services
- Federal or State governmental hospital (for example, Veteran Hospital or Prison Hospital) services
- Short-Doyle/Medi-Cal services

Authorization

Authorization of plan-capitated services must be directly obtained from SCAN or the participating Independent Physicians Association (IPA) in certain cases. The Medi-Cal field offices do not authorize capitated services. Authorization of non-capitated services is provided by the Medi-Cal field offices, and *Treatment Authorization Requests* (TARs) for those services must be submitted to the TAR Processing Center.

Border and Out-of-State Providers

Providers in designated border communities and out-of-state providers must obtain plan authorization when rendering services to plan members, except in case of an emergency.

Where to Submit Claims

Providers submit claims for capitated services to the plan. See the *MCP: Code Directory* section in this manual for plan address and telephone number information.

Providers submit claims for noncapitated services (FFS Medi-Cal) to the CA-MMIS FI as specified in the appropriate Part 2 provider manual.

Claim Completion for Copayments Coinsurance and Deductibles

Claims for copayments, coinsurance or deductibles must be submitted as paper claims. Instructions for submitting paper claims closely parallel the instructions for billing Medicare/Medi-Cal hard copy crossover claims. Therefore, billers should refer to the Hard Copy Submission Requirements of Medicare-Approved Services in the appropriate Part 2 manual.

In their interpretation of the manual, billers should consider VillageHealth the same as Medicare. For example, Medicare approved service would also be interpreted as VillageHealth approved service.

In addition, claims for copayments, insurance or deductibles treated like crossovers must be billed to Medi-Cal with the same national codes and modifiers billed to VillageHealth and include the following:

- A copy of the *Remittance Advice* received from VillageHealth. The RA must state “SCAN ESRD PILOT” for VillageHealth claims in the *Remarks* section at the bottom left and include the address and telephone number for the plan in the upper right corner.

Outpatient Clinic/Hospital Providers: The RA provided by VillageHealth must be in the Medicare National Standard Intermediary (Medicare RA) format equivalent to the latest PC Print single claim detail version with billed amounts, paid amounts, group codes, reason codes, amounts showing line level coinsurance, and deductible amounts and other adjustments, as appropriate.

- VillageHealth Automated Eligibility Verification System carrier code S323, as appropriate, in the *Insurance Plan Name or Program Name* field (Box 11C) on the *CMS-1500* claim or *Health Plan ID* field (Box 51) on the *UB-04* claim.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.